Special Terms and Conditions of Approval

CENTERS FOR MEDICARE AND MEDICAID SERVICES

NUMBER: 11-W-00163/6

TITLE: Arkansas TEFRA-like Demonstration

AWARDEE: Arkansas Department of Human Services, Division of Medical Services

The following are Special Terms and Conditions for the award of the TEFRA-like Medicaid section 1115 demonstration request submitted on July 18, 2002. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, and Attachments regarding General Financial Requirements, Monitoring Budget Neutrality, and a Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval will be sent to the Centers for Medicare and Medicaid Services (CMS) Central Office demonstration project officer and the State representative in the CMS regional office.

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I. GENERAL PROGRAM REQUIREMENTS AND AGREEMENTS

1. **Extension or Phase-out Plan.** Demonstration extension plans will be discussed with CMS at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it will submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

2. **Evaluation.** The State will design and conduct an evaluation of the demonstration program. The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally-funded evaluation of the demonstration program.

3. **CMS Right to Suspend or Preclude Demonstration Implementation.** The CMS may suspend or preclude Federal Financial Participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. If the State chooses to terminate this demonstration before the expiration date, it will notify CMS in writing at least 30 days prior to terminating services to participants. If CMS or the State terminates the demonstration, the State will, at least 30 days prior to terminating services, notify the participants of the services of the action it intends to take, notify them of the effective date of the action, and how the action will affect the participants.

5. **CMS Right to Terminate or Suspend Demonstration Operation.** During demonstration operation, CMS may suspend or terminate FFP for any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not otherwise matchable at any time if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal close-out costs.

II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items)

6. **Monthly Progress Calls.** Before and for 6 months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.

7. **Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft. The reports will address, at a minimum:
   - a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
   - notable accomplishments; and
   - problems/issues that were identified and how they were solved.

8. **Final Report.** At the end of the demonstration period, a draft final report will be submitted to CMS for comments. The CMS's comments shall be taken into consideration by the State for incorporation into the final report. The CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report with CMS's comments is due no later than 180 days after the termination of the project. The State will include a discussion of its evaluation results in the final report.

III. LEGISLATION

9. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in Federal laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

   If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

10. **Changes in Federal Law Affecting Medicaid.** The State will, within the timeframe specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

    If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without-waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

11. **Amending the Demonstration.** The State may submit an amendment for CMS consideration requesting exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance of the following:

12. **Preparation and Approval of Operational Protocol.** Prior to service delivery under this demonstration, an Operational Protocol document, which represents all policies and operating procedures applicable to this demonstration, will be prepared by the State and approved by CMS. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. *Requirements and required contents of the Operational Protocol are outlined in Section V of these Special Terms and Conditions.*

13. **Adequacy of Infrastructure.** Adequate resources for implementation, monitoring activities, and compliance to the Special Terms and Conditions of the TEFRA-like demonstration will be provided by the State.

14. Screen and Enroll and Opportunity for Choice. The State will facilitate outreach and enrollment into all appropriate title XIX programs. Families applying to participate in the TEFRA-like demonstration will be evaluated for likely eligibility in Arkansas title XIX programs. If found to be likely eligible for more than one program, the family will be counseled and given the opportunity to enroll in the program of their choice.

15. Evaluation and Monitoring Design. The State will conduct formative, and possible outcome, evaluations of the impact of the TEFRA-like demonstration on participants and eligibles. The state acknowledges the importance to CMS of formative evaluation to the operation, quality improvement and possible modifications to innovative demonstration initiatives. The evaluation will contain, at a minimum, the following aspects:

- Potential burden imposed by the premium structure of this demonstration on participants and eligibles; and
- Effect of this demonstration and its policies on the ability of the State to advance community integration and the goals of the Americans with Disabilities Act.

The State agrees to evaluate the need to revise the premium structure based on the experience gained from such monitoring activities.

16. Budget Neutrality. The cost of services provided during the demonstration will be no more than 100 percent of the cost to provide Medicaid services without the demonstration.

17. **Public Notice Requirements.** The demonstration complies with public notice requirements as published in the *Federal Register*, Vol. 59, No. 186 dated September 29, 1994, (Document number 94-23960) and Centers for Medicare & Medicaid Services (CMS) requirements regarding Native American Tribe consultation.

V. OPERATIONAL PROTOCOL

18. **Operational Protocol Timelines and Requirements**. The Operational Protocol will be submitted to CMS no later than 45 days prior to program implementation. The CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the Special Terms and Conditions, those issues being necessary to approve the Operational Protocol.

    FFP is not available for Medical Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions.

    While the material contained in the Operational Protocol must be approved prior to demonstration implementation, discussion of Arkansas's plan for a demonstration evaluation may be broad in nature, as the evaluation will not commence until post-implementation. CMS and State staff will collaborate post-implementation in ensuring the evaluation includes agreed-upon elements.

    Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, will be submitted for review by CMS. The State will submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

19. Required Contents of Operational Protocol:

a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details such as:

- a timeline of demonstration implementation tasks prior to and post implementation, including steps, estimated time of completion, and who will be responsible for items. (For example, necessary pre-implementation data systems changes, when edits will be made, when changes will be tested, and the responsible party.);
- claims processing; and
- enrollee premium/cost-sharing collections.

b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in the Special Terms and Conditions Section II and Attachments A and C of this document.

c. Premium & Cost-Sharing. A description of the calculation and collection of applicable premiums and enrollee cost-sharing. Include the following:

- premium and cost-sharing amounts;
- how they were calculated;
- how they will be reported to CMS (refer to items 2.d. and 6. of Attachment A of this document); and
- the process through which enrollees and providers will be informed of enrollee financial obligations.

d. Premium & Cost Sharing Protections. A description of the enrollee protections in place regarding State disenrollment of enrollees due to non-compliance with premiums and cost sharing requirements for demonstration participation, and how enrollees will be informed. For example:

- the grace period during which enrollees may make applicable premium and cost sharing payments without termination from the program;
- how the State will notify the enrollee that he or she has failed to make the required payment and may face termination from the program if the payment is not made;
- how the individual will be assured the right to appeal any adverse actions for failure to pay premiums and cost-sharing requirements; and
- the process in place to re-enroll the individual in the demonstration if payment of the required premium or cost sharing is paid.

e. Coordination with Private Health Insurance Coverage. A description of the penalties assessed on families who drop existing health insurance, along with the State's coordination of coverage efforts and policies for collecting Third Party Liability payments.

f. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, staff training strategy/schedule. NOTE: *All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:

- information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers, or contracted parties);
- types of media to be used;
- specific geographical areas to be targeted;
- locations where such information will be disseminated;
- staff training schedules, schedules for State forums or seminars to educate the public; and
- the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities;
- training provided to State staff regarding educating beneficiaries on the universe of title XIX program options available to them.

g. Eligibility/Enrollment. A description of the population of individuals eligible for the

demonstration (and eligibility exclusions), including plans for population phase-in. Describe the processes for the following, and include the State agency responsible for each of the processes:

- eligibility determination;
- annual redetermination;
- intake, enrollment, and disenrollment;
- screening for eligibility for any appropriate Arkansas title XIX program, in accordance with Assurance 15; and
- if applicable, procedures for determining the existence and scope of a demonstration applicant's existing third party liability;

h. Quality. An overall quality assurance monitoring plan that includes:

- a discussion of how the State will monitor operations of the program (personnel and systems);
- the system in place to trigger and alert State staff to issues that need attention;
- all quality indicators to be employed to monitor products delivered under the demonstration and methodology for measuring such indicators;
- the system in place to ensure that feedback from quality monitoring will be incorporated into the program;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
- fraud control provisions and monitoring; and
- monitoring for the effects of any undue burden on TEFRA families due to the premiums imposed through this demonstration, in accordance with Assurance 16.

i. Grievances and Appeals. If the grievances and appeals policies differ from non-demonstration Medicaid, then provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

j. Evaluation Design. A description of the State's evaluation design, including:

- a discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included in order to evaluate the impact of the demonstration;
- what data will be utilized;
- the methods of data collection;
- how the effects of the demonstration will be isolated from those other initiatives occurring in the State;
- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
- how the premium structure will be monitored against undue burden on participants/eligibles, institutional bias, and lack of compliance with the Olmstead Act, in accordance with Assurance 16.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. Applicable rebates and expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements will be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

b. For each demonstration year a separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures for individuals enrolled in the TEFRA-like demonstration. The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap (as defined in 2. c.). The procedures for the reporting of these expenditures will be described in the operational protocol.

c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of individuals who are enrolled in the TEFRA-like demonstration. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and/or 64.9P WAIVER.

d. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the demonstration will be reported to CMS on the CMS-64 Summary Sheet on Line 9.D, in order to assure Medicaid is properly credited with premium collections.

e. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs will be identified on the Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

f. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) will be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) will be made within 2 years after the conclusion or termination of the demonstration. During the latter 2 year period, the State will continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

g. The procedures related to this reporting process, report contents, and frequency will be discussed by the State in the Operational Protocol, to be included in the description in item 18.b. of Section V of this document.

3. a. For the purpose of calculating the budget neutrality expenditure cap described in this letter, the State shall provide to CMS on a quarterly basis the actual number of eligible member/months for the TEFRA-like demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Special Term and Condition II-8. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY shall be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months shall be defined in the Operational Protocol.

b. The term, "eligible member/months" shall refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. The term "TEFRA-like demonstration eligibles" refers to children 18 years of age or under, who would otherwise require institutional care, could otherwise be made Medicaid eligible if the State had such a program, and are also eligible for the TEFRA-like demonstration. The TEFRA-like demonstration consists of persons participating in the TEFRA-like demonstration.

4. The standard Medicaid funding process will be used during the demonstration. Arkansas must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal

fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State will submit the Form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.

c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B
MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the TEFRA-like demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Arkansas will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place Arkansas at risk for changing economic conditions. However, by placing Arkansas at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Projecting Service Expenditures

Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. The State fiscal year (SFY) 2002 base year cost is $715.35 monthly per person ($34,173,738.61/3981/12 = 715.35) and the trended amounts by SFY are the following:

State Fiscal Year	Trended Monthly Per Person Cost
CY2003	$ 802.89
CY2004	$ 867.12
CY2005	$ 936.49
CY2006	$ 1,011.41
CY2007	$ 1,092.32

Demonstration years which do not align with State fiscal years or which fall beyond the range of years shown will be calculated using an annual trend rate of 8% or a monthly trend rate of .643403%.

Using the trend rates to produce non-Federal fiscal year PMPM cost estimates
Because the beginning and the end of the demonstration are unlikely to coincide with either the Federal or State fiscal year, the following methodology will be used to produce DY estimates of PMPM cost. Using the monthly equivalent growth rate of .643403% and the appropriate number of months, a trend factor will be developed to convert SFY 2002 base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor of 8% will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations
First Demonstration Year:
As an example, assume that the base year (SFY ended 6/30/2002) per capita cost for the enrolled population is $715.35, and the first year of a demonstration (DY 2003) beginning January 1, 2003, and ends December 31, 2003. DY 2003 is 18 months in time beyond SFY 2002; therefore, the monthly trend factor must be applied to trend SFY 2002 cost forward to DY 2003. Applying the monthly trend factor to bring the base year estimate forward to DY 2003 results in PMPM cost of $802.89. ($802.89 = $715.35 x 1.00643403^{18}, or $715.35 x 1.122374).

Second and Subsequent Demonstration Years:
Since DY 2004 is 12 months beyond DY 2003, 12 months of growth factor are needed. Applying the 8 percent growth factor to the estimated DY 2003 PMPM cost of $802.89 gives a DY 2004 PMPM cost of $867.12.

Impermissible DSH, Taxes or Donations
The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Revising the Trended Monthly Per Person Cost (MPPC)
In demonstration programs where participation is voluntary and the participation rate represents a minority percentage of the Medicaid population, a revision to the trended monthly per person cost in specified demonstration year(s) may be considered by the State and CMS when the state implements provider fee increases that: 1) are irregular in nature; 2) materially exceed the agreed upon trend rate in the year the fee is implemented; and 3) are implemented through the State Plan and affect the cost of those services included in the demonstration budget neutrality cap on a statewide basis.

The intent of this provision is to protect the State from statewide fee increases that are:
1) pending at time of award, but could not be reasonably assessed prior to award or undefined at the time of award; 2) are not included in the historical state experience used in determining the

agreed upon budget neutrality cap; and 3) are not specifically targeted to the demonstration population.

The State, when requesting revision to the MPPC, must provide the following information to CMS on: 1) the full budget effect of the fee increase, including the amount and implementation dates of the current and past fee increases for all services in the MPPC; 2) the MPPC disaggregated by major service categories and number of services for each category, demonstrating the affect with and without the new rate increase; and 3) the current assessment and projections of with and without waiver costs.

How the limit will be applied

The limit calculated above will apply to actual expenditures for TEFRA-like demonstration services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and Post-implementation.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 45 days prior to implementation, CMS will respond within 30 days of receipt of the protocol regarding any issues requiring clarification or follow-up.	One Operational Protocol. Changes to the Operational Protocol will be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.